advocare | The Modern Woman OB/GYN

MEDICAL RECORD RELEASE AUTHORIZATION

TO:____
(Doctor, Hospital, or Medical Practice)

____
(Address)

_____________________________ _____________________________
(Phone) (Fax)

I hereby authorize and request you to release the complete history and records in your possession, concerning my health and/or treatments to:

advocare | The Modern Woman OB/GYN

Diana Huang, MD FACOG

131 Columbia Turnpike, Ste 1

Florham Park, NJ 07932

Tel: (973) 949-1286

Fax: +1 (855)540-2449 or (973) 949-0108

I specifically authorize the release of the following:

- ❑ During The Period of __________ to __________
- ❑ Complete Records
- ❑ Other (Please Specify): ____

Name: __________________________________ Date of Birth: _____________________

Address: ____

____ ______________________
Signature of Patient, Guardian, or Legal Representative Date